1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1a. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form BMS Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12777

12707

1. DECEASED-NAME (Type or Print) First	Middle	Lost
Helena	Dorothy	BANGERT

2a. DATE KNOWN OF DEATH ESTIMATED ☐ Month 9 Day 20 Year 1968 — 2b. HOUR 7:30 P.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS	DAYS	IF UNDER 24 HRS.: HOURS	MIN
female	white	2/23/17	51 YRS.				

2c. DATE PRONOUNCED DEAD Month 9 Day 20 Year 1968 — 2d. HOUR 10:30 P.M.

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Maryland	USA		Carroll Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
New Windsor		none	

13a. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Baltimore		YES ☒ NO ☐	2904 Dunmurry Road

14. FATHER'S NAME First	Middle	Lost	15. MOTHER'S MAIDEN NAME First	Middle	Lost
Joe	-	Runge	Frances	-	Plesek

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no	220-09-8833	Springfield Hospital records, Sykesville, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), ond (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease with

DUE TO, OR AS A CONSEQUENCE OF (b) obstruction of the left descending coronary artery.

Conditions, if ony, which gove rise to immediote couse (a), stoting the underlying couse last. 4129 287X

DUE TO, OR AS A CONSEQUENCE OF (c) Obesity.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Schizophrenic reaction, chronic undifferentiated type.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, form, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I taak charge af the remains described abave, held an Autapsy ☒, Inspectian ☐, Inquiry ☐, and in my apinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Hamicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE W. Glenn Speicher M.D.

EXAMINER'S NAME (Type) W. Glenn Speicher, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Street, City, County) 135 E. Main West minster Carroll

22b. DATE SIGNED 9-20-68

23a. BURIAL CREMATION REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
	9-26-'68	U. of Md. Med. School	Baltimore Md.

24. FUNERAL DIRECTOR ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Reese Funeral Home Reisterstown	OCT 8 1968	J. Charles Jones

VR A15ME (5) 10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12778 — 12788

1. DECEASED-NAME (Type or print): First MARY; Middle NMN; Last Billips
2a. DATE OF DEATH: Month Sept. Day 14 Year 1968
2b. HOUR: 9.05 AM
3. SEX: FEMALE
4. RACE: NEGRO
5. DATE OF BIRTH: JUNE 9. 1902
6. AGE (In years last birthday): 66 YRS. IF UNDER 1 YEAR: MONTHS; DAYS. IF UNDER 24 HRS.: HOURS; MIN.
7a. BIRTHPLACE (State or foreign country): VIRGINIA
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
9. COUNTY OF DEATH: CARROLL Md.
10. CITY OR TOWN OF DEATH: Sykesville
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Springfield St. Hospital
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): UNKOWN
12b. KIND OF BUSINESS OR INDUSTRY:
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md
13b. COUNTY: —
13c. CITY OR TOWN: BALTIMORE
13d. INSIDE CITY LIMITS? YES ☑ NO ☐
13e. STREET AND NUMBER: 581 Dolphin St.
14. FATHER'S NAME: First SAM; Middle; Last THAXTON
15. MOTHER'S MAIDEN NAME: First UNKNOWN; Middle; Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16b. SOCIAL SECURITY NO.: 219-58-6055
17. INFORMANT: Hospital Records. Address: Sykesville Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF (b): A.S.C.V.D.
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 410.9 420.1
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: HOURS / years.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Mod. Adv. P.T.B. inactive. C.B.S. ass. with Cerebral arteriosclerosis

MEDICAL CERTIFICATION

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☑
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from Dec. 15, 1964, to Sept 14 1968, that (I) (we) last saw the deceased alive on Sept. 14 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Agustin del Campo MD DEGREE — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☑
22c. DATE SIGNED: Sept. 14 68
22d. PHYSICIAN'S NAME (Type): Agustin del Campo, M. D.
22e. ADDRESS: Sykesville Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 9/20/68
23c. NAME OF CEMETERY OR CREMATORY: I.O.O.F. Cemetery Board
23d. LOCATION (City or Town) (County) (State): Baltimore, Md.
24. FUNERAL DIRECTOR: Frank H. Howell, Sykesville, Md.
ADDRESS:
25a. REC'D BY REGISTRAR DATE: SEP 27 1968
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (N) 30M REV. 1-68

1

12779

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12789

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Maude	Middle A.	Last Bloom.
2a. DATE OF DEATH Month Day Year	9 - 20 - 68	2b. HOUR	11:45 M
3. SEX	F	4. RACE	W
5. DATE OF BIRTH	April 24, 1879	6. AGE (In years last birthday)	89 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country)	Harford Co. Penn.	7b. CITIZEN OF WHAT COUNTRY?	USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐		9. COUNTY OF DEATH	Carroll Md.
10. CITY OR TOWN OF DEATH	Manchester, Md.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	125 N Main St. Longview Nursing Home
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	Housewife	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	Md.	13b. COUNTY	Carroll.
13c. CITY OR TOWN	Hampstead	13d. INSIDE CITY LIMITS? YES ☑ NO ☐	13e. STREET AND NUMBER 130 N Main St.
14. FATHER'S NAME First	Isaac	Middle Thomas	Last Long.
15. MOTHER'S MAIDEN NAME First	Martha	Middle Ellen	Last Black.
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	No	16b. SOCIAL SECURITY NO.	220-54-7734
17. INFORMANT (daughter)	Mabel Starner	Address	130 N Main St. Hampstead Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arterio Sclerotic Cardiovascular Disease — Approximate interval between onset and death: 4 Years

DUE TO, OR AS A CONSEQUENCE OF (b) Arterio-Sclerosis Brain — 4 Years

DUE TO, OR AS A CONSEQUENCE OF (c) Moderate Hypertension

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4120

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

443X Bilateral Glaucoma Several yrs

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (this hospital) attended the deceased from 5-14, 1963, to 9-20, 1968, that (I) (we) last saw the deceased alive on 9-17, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (~~did not~~) view the body after death.

22b. SIGNATURE	W. Glenn Speicher	DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED 9-20-68
22d. PHYSICIAN'S NAME (Type)	Dr. W. Glenn Speicher	22e. ADDRESS	Westminster, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)	
Burial	9/23/1968	Linganore Cemetery	Unionville,	Frederick, Md.
24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE	
C. M. Waltz, Box 241, Sykesville, Md.		SEP 24 1968	Charles Judge	

VR A15 (4) 30M REV 7-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12780 12790

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

1. DECEASED-NAME (Type or print)	First: Mary	Middle: Elizabeth	Last: Briedenstein	2a. DATE OF DEATH: 9 Month 26 Day 68 Year	2b. HOUR: 6:55 am M	
3. SEX: female	4. RACE: white	5. DATE OF BIRTH: 11/1/79	6. AGE (In years last birthday): 88 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Carroll Md.			
10. CITY OR TOWN OF DEATH: Rural--Sykesville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Springfield State Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): housewife	12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Bethesda	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 5721 Grosvenor Lane		
14. FATHER'S NAME First: ?	Middle	Last	15. MOTHER'S MAIDEN NAME First: ?	Middle	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): no (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 579-03-6108	17. INFORMANT: Springfield Hospital records, Sykesville, Md.	Address			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia
DUE TO, OR AS A CONSEQUENCE OF
(b): Generalized arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 437.9 334.X

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: days / years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Chronic brain syndrome associated with cerebral arteriosclerosis with psychotic reaction.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. I certify that ☒ (this hospital) attended the deceased from 5/16/, 19 68, to 9/26/, 19 68, that ☒ (we) last saw the deceased alive on 9/26/ 19 68, and that in ☒ (our) opinion death occurred on the date and hour and from the causes stated above. ☒ (We) (did) ~~did not~~ view the body after death.

22b. SIGNATURE: Naci N Buyukunsal M.D. DEGREE	ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒	22c. DATE SIGNED: 9/26/68	
22d. PHYSICIAN'S NAME (Type): Naci N. Buyukunsal, M.D.	22e. ADDRESS: Springfield State Hospital Sykesville, Maryland		

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation	23b. DATE: 9-26-68	23c. NAME OF CEMETERY OR CREMATORY: Lee's Crematory	23d. LOCATION (City or Town): Washington, D.C.	(County) (State): 20002
24. FUNERAL DIRECTOR: Lee Funeral Home	ADDRESS: Washington, D.C. 20002	25a. REC'D BY REGISTRAR DATE: SEP 27 1968	25b. REGISTRAR'S SIGNATURE: J Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12781 — 12791

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Edith	Leontine	Bryant	Sept.	5	1968	3:55A M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
Female	White	2-3-95	73 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Maryland	U.S.A.		Carroll County Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Sykesville, Md.	Springfield St. Hosp.	Clothing examiner	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER
Md.	Balt. City	Baltimore		2614 E. Chase Street

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Lebin	Herbert	Bryant	Anna	C.	Flippin

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT (Cousin) Address
no	216-05-0250	Margaret Mongold, 3812 Lyndale Avenue Records, Springfield St. Hosp., Sykesville

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cronic Debilitation

DUE TO, OR AS A CONSEQUENCE OF

(b) Senility

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 437.9 334x

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Chronic brain syndrome associated with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While ☐ at work Not while ☐ at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that (I) (this hospital) attended the deceased from 11-10, 19 54, to ____, 19 ____, that (I) (we) last saw the deceased alive on ____ 19 ____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS. ☐	MED. DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED
Jose A. Raquel Jr.	M.D.				9/5/68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Jose A. Raquel, Jr. M.D.	

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	9/7/68	Parkwood Cemetery	Balto., Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Schimunek Funeral Home 3331 Brehms Lane 21213	SEP 9 1968	Charles Judge

VR A15 (4) 30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12782 — 12792

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	MELVIN	Middle F.	Last BURDETTE
2a. DATE OF DEATH Month Day Year	Sept. 25 1968	2b. HOUR	4 PM
3. SEX	Male		
4. RACE	White		
5. DATE OF BIRTH	Aug. 9, 1889		
6. AGE (In years last birthday)	79 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country)	Maryland		
7b. CITIZEN OF WHAT COUNTRY?	U.S.A.		
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]			
9. COUNTY OF DEATH	Carroll Md.		
10. CITY OR TOWN OF DEATH	New Windsor		
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	Route 1		
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	Laborer		
12b. KIND OF BUSINESS OR INDUSTRY	Farming		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	Maryland		
13b. COUNTY	Carroll		
13c. CITY OR TOWN	New Windsor		
13d. INSIDE CITY LIMITS? YES [ ] NO [X]			
13e. STREET AND NUMBER	Route 1 - Box 125		
14. FATHER'S NAME First	James	Middle T.	Last Burdette
15. MOTHER'S MAIDEN NAME First	~~Sarah~~ Irene	Middle	Last Long
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	Yes WW 1		
16b. SOCIAL SECURITY NO.	213-18-9182		
17. INFORMANT Address	Mrs. Sarah A. Burdette		Same As #13

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arteriosclerotic C.V.D. — years

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

4129

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

4221

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. I **certify** that (I) (this hospital) attended the deceased from 9/19/48, 19___, to 9/25/68, 19___, that (I) ~~(saw)~~ last saw the deceased alive on 9/24/48 19___, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ (did) ~~(did not)~~ view the body after death.

22b. SIGNATURE	M.E. Robertson M.D.	DEGREE	ATTENDING PHYS. [X]	MED. DIRECTOR [ ]	STAFF PHYS. [ ]
22c. DATE SIGNED	9/25/68				
22d. PHYSICIAN'S NAME (Type)	Dr. M. E. Robertson				
22e. ADDRESS	New Windsor, Md.				

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)	
Burial	9/28/1968	Locust Grove	Frederick, Md.	
24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE	
C. M. Waltz,	Box 241, Sykesville, Md.	SEP 27 1968	J. Charles Judge	

VR A15(M) 30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12783 12793

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR
Evelyn	Marie	Christ	Sept.	21,	1968	6:15 AM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS. HOURS	IF UNDER 24 HRS. MIN.
Female	White	Aug. 28, 1910	58 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Maryland	U.S.A.		Carroll Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Finksburg	Route 32	Housewife	Home

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER
Md.	Carroll	Finksburg		Box 21 Route 32

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Mark	Rice	Woodbury	Unk.		

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	—	?	Mr. John Christ III	Finksburg, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Malnutrition — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 mos
DUE TO, OR AS A CONSEQUENCE OF
(b) Carcinoma Lung — 4 mo.
DUE TO, OR AS A CONSEQUENCE OF
(c)

1621
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
163x

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
6/5/68	Biopsy		YES

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** thot (I) (this hospitol) attended the deceased from June, 19 68, to Sept, 19 68, that (I) (~~we~~) last saw the deceased alive an Sept. 11 1968, and thot in (my) (~~our~~) opinian death occurred an the date and hour and from the couses stoted above, (I) (we) (did) (did nat) view the body ofter death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Martin E. Strobel, M.D.		☒	☐	☐	9/21/68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
MARTIN E. STROBEL	REISTERSTOWN, MD

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	9-24-68	Lakeview Cemetery	Sykesville Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Harry W. Haight	Sykesville, Md	SEP 24 1968	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate hos been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the buriol-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to buriol, cremation, or removol, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12784 — 12794

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
MARY	M.	COVINGTON	9	15	68	1045 AM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
FEMALE	WHITE	6-17-74	94 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Maryland	U.S.A.		CARROLL COUNTY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Sykesville, Md.	SPRINGFIELD STATE HOSP. SYKESVILLE, MD	HOUSEWIFE	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	—	BALTIMORE	YES ☒ NO ☐	3007 Ellerslie Ave.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
August		Hoffmann	FRANCES		Wehner

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
NO	217-18-0012-B	SPRINGFIELD STATE HOSP. SYKESVILLE MD.

MEDICAL CERTIFICATION

1B. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebrovascular Accident

DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Arteriosclerosis

DUE TO, OR AS A CONSEQUENCE OF (c) Terminal Pneumonitis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4369

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Days / Years / Hours

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

331X

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 9-10, 1968, to 9-15, 1968, that (I) (we) last saw the deceased alive on 9-15-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Renato R. Espina, MD	MD	☐	☑	☐	September 15, 1968

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
RENATO R. ESPINA, MD	SPRINGFIELD STATE HOSPITAL

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	9/18/68.	Vernon Cemetery	White Hall, Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Leonard J. Ruck, Inc.	Balto. Md. 21214	SEP 17 1968	[illegible]

VR A15 (4)
30M REV. 1-68

4 1

12785

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12795

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First / Middle / Last	Clement Leroy DIETRICH	2a. DATE OF DEATH Month Day Year	September 11, 1968	2b. HOUR	11:00 A M
3. SEX	Male	4. RACE	White	5. DATE OF BIRTH	7/2/98
6. AGE (In years last birthday)	70 YRS.	IF UNDER 1 YEAR MONTHS / DAYS		IF UNDER 24 HRS. HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country)	Maryland	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	
9. COUNTY OF DEATH	Carroll County, Md.				
10. CITY OR TOWN OF DEATH	Sykesville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	Springfield State Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	Storekeeper
12b. KIND OF BUSINESS OR INDUSTRY	Hospital				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	Maryland	13b. COUNTY	Carroll	13c. CITY OR TOWN	Sykesville
13d. INSIDE CITY LIMITS? YES [ ] NO [X]		13e. STREET AND NUMBER	Route #4		
14. FATHER'S NAME First / Middle / Last	Edwin Dietrich	15. MOTHER'S MAIDEN NAME First / Middle / Last	Margaret Cromwell		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	unknown —	16b. SOCIAL SECURITY NO.	219 36 2048	17. INFORMANT Address	Records, Springfield State Hospital

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac arrest, due to — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: minutes

DUE TO, OR AS A CONSEQUENCE OF

(b) Possible acute myocardial infarction — minutes

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109 4201

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Chronic brain syndrome associated with cerebral arteriosclerosis with psychotic reaction.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] DR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that (I) (this hospital) attended the deceased from 7/26, 19 65, to 9/11, 19 68, that (I) (we) last saw the deceased alive on 9/11/68 19___, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	Octavio A Ruiz M.D. DEGREE	ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]	22c. DATE SIGNED 9/11/68
22d. PHYSICIAN'S NAME (Type)	Octavio A. Ruiz, M.D.	22e. ADDRESS	Springfield State Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	Burial	23b. DATE	9-14-68	23c. NAME OF CEMETERY OR CREMATORY	Springfield Cemetery
23d. LOCATION (City or Town)	Sykesville,	(County)		(State)	Md.
24. FUNERAL DIRECTOR	Harry W. Haight	ADDRESS	Sykesville, Md.	25a. RCVD BY REGISTRAR DATE	SEP 13 1968
25b. REGISTRAR'S SIGNATURE	J. Charles Judge				

VR A15 (M)
30M REV. 1-68

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil — Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

12786 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12796

1. DECEASED-NAME (Type or Print) First / Middle / Last	WESLEY EUGENE ELSEROAD				2a. DATE KNOWN OF DEATH ESTIMATED	Month 9 Day 30 Year 1968	2b. HOUR 4:30 P.M.
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	2c. DATE PRONOUNCED DEAD Month 9 Day 30 Year 1968	2d. HOUR 4:30 P.M.
M	W	2-15-12	56 YRS.				
7a. BIRTHPLACE (State or foreign country)	Carroll Co. Md.	7b. CITIZEN OF WHAT COUNTRY?	USA	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED		9. COUNTY OF DEATH	Carroll Md.
10. CITY OR TOWN OF DEATH	Westminster	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	Carroll CO. Hospt.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	Plumber	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	Md.	13b. COUNTY	Carroll	13c. CITY OR TOWN	Finksburg	13d. INSIDE CITY LIMITS? YES / NO *	13e. STREET AND NUMBER RD
14. FATHER'S NAME First / Middle / Last	Charles W. Elseroad			15. MOTHER'S MAIDEN NAME First / Middle / Last	Mary Bowman		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	NO	16b. SOCIAL SECURITY NO.	218-14-2681	17. INFORMANT ADDRESS	Mrs. Herbert Allgire Hampstead, Md.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Shock
DUE TO, OR AS A CONSEQUENCE OF (b) Multiple Rib Fractures & Vertebra
DUE TO, OR AS A CONSEQUENCE OF (c) Hemorrhage
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 881X

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3½ hrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). 9010

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES / NO X
21a. EXTERNAL CAUSE WAS PRIMARY X OR CONTRIBUTING CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. 6:00 P.M. 9/30 1968	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	Stepped from ladder fell on roof of Tool House & Fell to ground
21d. INJURY OCCURRED WHILE AT WORK X / NOT WHILE AT WORK	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	
	His Home	RD1 Finksburg	Carroll Md

22a. **I certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE W. Glenn Speicher M.D.
EXAMINER'S NAME (Type)
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ADDRESS (Street or R.F.D., Town or City) 135 Emory Westminster Carroll
22b. DATE SIGNED 9-30-68

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)	
Burial	Oct. 3, 1968	Wesley Cemetery	Hampstead Carroll CO. Md.	
24. FUNERAL DIRECTOR ADDRESS	Tipton - Eline Funeral Home Hampstead, Md.	25a. REC'D BY REGISTRAR DATE	OCT 3 1968	25b. REGISTRAR'S SIGNATURE J. Charles Judge

VR A15ME (5)
10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12787 — 12797

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: Lillian	Middle: Charlotte	Last: ZEESER	2a. DATE OF DEATH Month: Sept	Day: 13 Year: 1968
2b. HOUR	10:45 A.M.				
3. SEX	Female	4. RACE	White	5. DATE OF BIRTH	Feb 2 1900
6. AGE (In years last birthday)	68 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country)	Balto. City	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Carroll Md.
10. CITY OR TOWN OF DEATH	Manchester Md	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	128 E. MAIN Longview Nursing Home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	House wife
12b. KIND OF BUSINESS OR INDUSTRY	None				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	Maryland	13b. COUNTY	Howard	13c. CITY OR TOWN	Ellicott City
13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER	437 Mount Hebron			
14. FATHER'S NAME First	George	Middle: Casper	Last: Weaver	15. MOTHER'S MAIDEN NAME First	Bessie
Middle		Last	Lucas		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	NO	16b. SOCIAL SECURITY NO.	215-08-6669	17. INFORMANT	Chester Jessup 437 Mt. Hebron Drive Ellicott City Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Myocarditis
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardio Vascular Disease
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if ony, which gave rise to immediate couse (a), stating the underlying couse lost. 4129
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4221

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County Stote	

22a. **I certify** that (I) (this hospital) attended the deceased from June 8, 1968, to Sept 13, 1968, that (I) (~~we~~) last saw the deceased alive on Sept 13 1968, and that in (my) (~~our~~) apinion death accurred on the dote and hour ond from the couses stoted above, (I) (~~we~~) (did) (~~did not~~) view the bady ofter death.

22b. SIGNATURE: Joseph E Bush MD — DEGREE — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22c. DATE SIGNED: 9-13-68

22d. PHYSICIAN'S NAME (Type) Joseph E Bush MD — 22e. ADDRESS HAMPSTEAD Maryland

23a. (BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (Stote)	
Burial	9-16-68	Baltimore Cemetery	Baltimore, Maryland	
24. FUNERAL DIRECTOR ADDRESS	Ellsworth Armacost-4600 Liberty Hghts. Ave.	25a. RECD BY REGISTRAR DATE	SEP 17 1968	25b. REGISTRAR'S SIGNATURE

VR A1514
30M REV. 11-68

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any deloy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (3)
10M REV. 1/68

12788

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12798

1. DECEASED-NAME (Type or Print) First: LESTER	Middle: IRVING	Last: FLOHR	2a. DATE KNOWN OF DEATH ESTIMATED ☐ Month: 9 Day: 6 Year: 1968	2b. HOUR: 8:20 A M			
3. SEX: M	4. RACE: W	5. DATE OF BIRTH: SEPT 21-1919	6. AGE (In years last birthday): 48 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	2c. DATE PRONOUNCED DEAD Month: 9 Day: 6 Year: 1968	2d. HOUR: 8:35 A M		
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: CARROLL Md.				
10. CITY OR TOWN OF DEATH: UNION BRIDGE	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 37N MAIN ST	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): DRIVER	12b. KIND OF BUSINESS OR INDUSTRY: TRUCK				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: CARROLL	13c. CITY OR TOWN: UNION BRIDGE	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 37N MAIN ST.			
14. FATHER'S NAME First: CLIFFORD	Middle	Last: FLOHR	15. MOTHER'S MAIDEN NAME First: LULA	Middle	Last: OTTO		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 218-07-7152	17. INFORMANT: DORIS FLOHR	ADDRESS: UNION BRIDGE MD				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gunshot Wound Skull — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if ony, which gove rise ta immediate cause (a), stoting the underlying couse lost. 955X 976X

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Injured Chest 9-4-68 2 Fractured Ribs

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year; HOUR A.M. / P.M.: 9-6 1968	21c. HOW INJURY OCCURRED (Enter noture of injury in Port I or Part 2, Item 18.): Pat Gun Barrel Center Forehead Pistol Target
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.): Home	21f. LOCATION Street or R.F.D. No.: 37 Main St; City or Town: Union Bridge; County: Carroll; State: Md

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: W Glenn Speicher M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): W GLENN SPEICHER
ADDRESS (Street, city, town, or county): 136 E Main St Westminster Carroll
22b. DATE SIGNED: 9-6-68

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	9/9/68	MT OLIVET	FREDERICK MD

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
D D Hartzler & Sons	Union Bridge Md	SEP 10 1968	J Charles Jones

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12789 12799

1. DECEASED-NAME (Type or print): First Mabel Middle Bennett Last GARDNER
2a. DATE OF DEATH: 9 Month 23 Day 68 Year
2b. HOUR: 8:45 PM
3. SEX: Female
4. RACE: White
5. DATE OF BIRTH: Sept. 15, 1893
6. AGE (In years last birthday): 75 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (State or foreign country): MARYLAND
7b. CITIZEN OF WHAT COUNTRY? U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. COUNTY OF DEATH: Carroll Md.
10. CITY OR TOWN OF DEATH: Sykesville
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Pullen Nursing Home
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife
12b. KIND OF BUSINESS OR INDUSTRY: Home
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.
13b. COUNTY: Carroll
13c. CITY OR TOWN: Sykesville
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: 1st Ave.
14. FATHER'S NAME: First John Middle Roberts Last Bennett
15. MOTHER'S MAIDEN NAME: First Hannah Middle Elizabeth Last Shipley
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.: ?
17. INFORMANT: Mr. Richard Gardner Address: Sykesville, Md.

MEDICAL CERTIFICATION

1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Diabetic Coma — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.
DUE TO, OR AS A CONSEQUENCE OF
(b) ASCVD — 10 yrs.
DUE TO, OR AS A CONSEQUENCE OF
(c) Diabetes Mellitus — 6 yrs.
2509
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
260 X

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 6/12, 19 64, to 9/23, 19 68, that (I) (we) last saw the deceased alive on 9/6 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Sani Okutman DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 9/24/68
22d. PHYSICIAN'S NAME (Type): Sani Okutman, M.D.
22e. ADDRESS: Obrecht Rd., Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: 9-26-68
23c. NAME OF CEMETERY OR CREMATORY: Springfield Cemetery
23d. LOCATION (City or Town) (County) (State): Sykesville, Md.
24. FUNERAL DIRECTOR: Harry W. Haight ADDRESS: Sykesville, Md.
25a. REC'D BY REGISTRAR DATE: SEP 30 1968
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 4 30M REV. 68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12790 — 12500

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VR A 5-M4
30M REV. 11-68

1. DECEASED-NAME (Type or print) First / Middle / Last	Carroll D. Giggard	2a. DATE OF DEATH Month / Day / Year	Sept. 28 1968
2b. HOUR	9:30 A M		
3. SEX	Male	4. RACE	White
5. DATE OF BIRTH	June 3, 1897	6. AGE (In years last birthday)	71 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country)	Carroll, Md.	7b. CITIZEN OF WHAT COUNTRY?	USA
8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐		9. COUNTY OF DEATH	Carroll CO. Md.
10. CITY OR TOWN OF DEATH	Westminster	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	Carroll Co. General Hospt.
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	Huckster	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	Md.	13b. COUNTY	Carroll
13c. CITY OR TOWN	Manchester	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	
13e. STREET AND NUMBER	Rd.		
14. FATHER'S NAME First / Middle / Last	Adam Giggard	15. MOTHER'S MAIDEN NAME First / Middle / Last	Lizzie Mathias
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	NO	16b. SOCIAL SECURITY NO.	220-18-1844
17. INFORMANT Address	Mary Giggard Manchester, Md. (Wife)		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis
DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Heart Disease
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditians, if any, which gave rise to immediote couse (a), stating the underlying cause last.
4109
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4200

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	Caunty / State

22a. **I certify** that (I) (this haspital) attended the deceased from Sept 27, 1968, to Sept 28, 1968, that (I) (we) lost saw the deceased alive on Sept 28, 1968, and that in (my) (our) opinian death accurred an the date and hour ond from the couses stated abave, (I) (we) (did) (did not) view the bady after death.

22b. SIGNATURE	John S. Harshey, M.D.	DEGREE	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐
22c. DATE SIGNED	9/28/68				
22d. PHYSICIAN'S NAME (Type)	JOHN S. HARSHEY, M.D.	22e. ADDRESS	8 Church St. Westminster, Md		

23a. BURIAL, CREMATION, REMOVAL (Specify)	Burial	23b. DATE	Oct 1, 1968	
23c. NAME OF CEMETERY OR CREMATORY	Immanuel Cemetery	23d. LOCATION (City or Town) (Caunty) (State)	Manchester Carroll Md.	
24. FUNERAL DIRECTOR ADDRESS	Tipton - Eline Funeral Home Hampstead, Md.	25a. REC'D BY REGISTRAR DATE	OCT 2 1968	25b. REGISTRAR'S SIGNATURE Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12791 — 12801

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 5-4(A) 30M REV 1-68

1. DECEASED-NAME (Type or print) First	GEORGE	Middle E.	Last GLASS
2a. DATE OF DEATH Month Day Year	Sept. 4 1968	2b. HOUR	9 P.M
3. SEX	Male		
4. RACE	White		
5. DATE OF BIRTH	March 17, 1883		
6. AGE (In years last birthday)	85 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country)	Maryland	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒		9. COUNTY OF DEATH	Carroll Md.
10. CITY OR TOWN OF DEATH	New Windsor	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	Horton Nursing Home
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	Laborer	12b. KIND OF BUSINESS OR INDUSTRY	Farming
13a. USUAL RESIDENCE (Where deceased lived, if institutian: Residence before admission) STATE	Maryland	13b. COUNTY	Carroll
13c. CITY OR TOWN	Mt. Airy	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	
13e. STREET AND NUMBER	Route 2		
14. FATHER'S NAME First	David	Middle J.	Last Glass
15. MOTHER'S MAIDEN NAME First	Cora	Middle A.	Last Horton
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	No	16b. SOCIAL SECURITY NO.	212-32-4927
17. INFORMANT	Charless Diller	Address	Same As #13

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Carcinomatosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

185 X

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma - Prostate — unknown

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

177 X

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Port 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (this hospitol) attended the deceased from 7/25/48, 19__, to 9/4/48, 19__, that (I) ~~(was)~~ last saw the deceased alive an 9/4/48 19__, and that in (my) ~~(our)~~ opinion death accurred on the date and haur and from the causes stoted abave, (I) ~~(we)~~ (did) ~~(did not)~~ view the body ofter death.

22b. SIGNATURE	M. E. Robertson MD	DEGREE	ATTENDING PHYS. ☑	MED. DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED 9/4/68
22d. PHYSICIAN'S NAME (Type)	Dr. M. E. Robertson	22e. ADDRESS	New Windsor Md			

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)	
Burial	9/7/1968	Bethany Cemetery	Carroll, Md.	
24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE	
C. M. Waltz, Box 241, Sykesville, Md.		SEP 9 1968	J. Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12792 — 12802

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, ar removal, and in any event, within 72 hours after death.

VR A15(a) 30M REV. 1-68

1. DECEASED-NAME (Type or print)	First: ~~Frank~~ Herman	Middle:	Last: Harrison	2a. DATE OF DEATH Month: 9	Day: 5	Year: 68	2b. HOUR: 8:15 AM
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: 6-20-01	6. AGE (In years last birthday): 67 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.		
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Carroll County Md.				
10. CITY OR TOWN OF DEATH: Sykesville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Springfield St. Hosp.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): ---- NONE	12b. KIND OF BUSINESS OR INDUSTRY: None				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Prince Georges A.A.	13c. CITY OR TOWN: Glen Burnie	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: Box 251			
14. FATHER'S NAME First Middle Last: Frank P. Harrison	15. MOTHER'S MAIDEN NAME First Middle Last: Maggie B. Freeland						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): no (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 219-54-4901	17. INFORMANT Address: Springfield State Hospital Records					

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Coronary thrombosis-Myocardial infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: hrs.

410.9

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. 4201

DUE TO, OR AS A CONSEQUENCE OF (b): Auricular fibrillation — mths

DUE TO, OR AS A CONSEQUENCE OF (c): Arteriosclerotic heart disease — yrs.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL CONDITION OR CONDITIONS GIVEN IN PART 1 (Marive's hereditary cerebellar ataxia)

Mental Defective with other Organic Nervous Disease, Other

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that ~~I~~ (this hospital) attended the deceased from 8/4/27, 19____, to 9/5/68, 19____, that ~~I~~ (we) last saw the deceased alive on ~~9-5-68~~ 8:15 1968, and that in (~~my~~ our) apinian death accurred an the date and haur and fram the causes stated abave, ~~I~~ (we) (did) ~~did not~~ view the bady after death.

22b. SIGNATURE	DEGREE: ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒	22c. DATE SIGNED
R. Hera.		9-5-68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Rene' A. Hera R. RENE A. HERA.	Springfield State Hospital

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	9-7-68	Springfield	Sykesville, Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Luther A. Haught	Sykesville Md	SEP 10 1968	J. Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P.M.3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used os o burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removol, and in any event within 72 hours after death.

VR A15ME(S)
10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12793 12803

1. DECEASED-NAME (Type or Print) First	Middle	Last
FRANK		HAWKINS

2a. DATE KNOWN OF DEATH ESTIMATED — Month: Sept. 1 — Day — Year: 1968 — 2b. HOUR: 8:40 M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
Male	Negro	8-9-36	32 YRS.		

2c. DATE PRONOUNCED DEAD — Month: Sept — Day: 1 — Year: 19 68 — 2d. HOUR: 2:15 M

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Maryland	U.S.A.	NEVER MARRIED [X]	Carroll Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Sykesville	Springfield State Hospital	none	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	—	Baltimore	YES [X] NO [ ]	1524 Druid Hill Ave.,

14. FATHER'S NAME First / Middle / Last	15. MOTHER'S MAIDEN NAME First / Middle / Last
Sol Booker	Ida Hawkins

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No		Records, Springfield State Hospital, Sykesville

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute pulmonary artery embolism	minutes
DUE TO, OR AS A CONSEQUENCE OF (b)		
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. 450 X 465 x

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Schizophrenic reaction, catatonic type

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES [X] NO [ ]

21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, form, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** thot I took chorge of the remoins described obove, held on Autopsy [X], Inspection [ ], Inquiry [ ], ond in my opinion deoth resulted from: Noturol couses [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined monner [ ]

ACTUAL SIGNATURE M.C. Porterfield M.D.

EXAMINER'S NAME (Type) M. C. Porterfield, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X] acting
ADDRESS(Street, city, town, or county)

22b. DATE SIGNED Sept. 1, 1968

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	9/7/68	Mt Calvary Cemetry	A A County Md

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Adolphus Halstead 1206 W North Ave	SEP 6 1968	J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12794 12804

1. DECEASED-NAME (Type or print): First Louise Middle S. Last Hicks
2a. DATE OF DEATH: Month 9 Day 15 Year 68
2b. HOUR: 2:30 PM
3. SEX: Female
4. RACE: Cauc.
5. DATE OF BIRTH: 11 July 06
6. AGE (In years last birthday): 62 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (State or foreign country): Baltimore Md. U.S.A.
7b. CITIZEN OF WHAT COUNTRY?
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. COUNTY OF DEATH: CARROLL Co. Md.
10. CITY OR TOWN OF DEATH: Westminster
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): CARROLL County GEN.
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): HOUSE-WIFE
12b. KIND OF BUSINESS OR INDUSTRY:
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.
13b. COUNTY: CARROLL
13c. CITY OR TOWN: Westminster
13d. INSIDE CITY LIMITS? YES [ ] NO [X]
13e. STREET AND NUMBER: 192 FAIRFIELD AVE.
14. FATHER'S NAME First Joseph Middle H. Last Sanders
15. MOTHER'S MAIDEN NAME First ELIZABETH Middle Last FOXWELL
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO
16b. (If yes give war or dates of service) —
16b. SOCIAL SECURITY NO. 054-38-2716
17. INFORMANT: MR. W. RAYMOND HICKS, WESTMINSTER, MD. Address 192 FAIRFIELD AVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Carcinoma of Brain — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 y.
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 174X

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
170X

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES [ ] NO [X]
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Manth Day Year 19
21c. HOW INJURY OCCURRED (Enter noture af injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work [ ] Nat while at work [ ]
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from July, 1967, to Sept 15, 1968, that (I) (we) last saw the deceased alive on 14 Sept 1968, and that to (my) (aur) apinian death occurred an the date and haur and fram the causes stated abave; (I) (we) (did) (did nat) view the bady after death.

22b. SIGNATURE: Dean H. Griffin
DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22c. DATE SIGNED: 15 Sept 68
22d. PHYSICIAN'S NAME (Type): DEAN H. GRIFFIN, M.D.
22e. ADDRESS: RIDGE ROAD, WESTMINSTER, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): CREMATION
23b. DATE: 9/17/68
23c. NAME OF CEMETERY OR CREMATORY: GREENMOUNT CEMETERY
23d. LOCATION (City or Town) (County) (State): BALTIMORE, MD.
24. FUNERAL DIRECTOR: J. E. Myers, Jr.
ADDRESS: Westminster, Md.
25a. REC'D BY REGISTRAR DATE: SEP 17 1968
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar ta burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (2)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12795

CERTIFICATE OF DEATH

12805

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: Madge	Middle: G.	Last: Hill	2a. DATE OF DEATH: 9 Month 16 Day 68 Year	2b. HOUR: 2:05 am M	
3. SEX: female	4. RACE: Negro	5. DATE OF BIRTH: 5/10/88	6. AGE (In years last birthday): 80 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Carroll Md.			
10. CITY OR TOWN OF DEATH: Rural--Sykesville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Springfield State Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): none	12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) STATE: Md.	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Sandy Spring	13d. INSIDE CITY LIMITS? YES [ ] NO [ ]	13e. STREET AND NUMBER: Brook Road		
14. FATHER'S NAME First: Bracin	Middle: -	Last: Cook	15. MOTHER'S MAIDEN NAME First: Mary	Middle: -	Last: ?	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: no (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 214-20-9833-A	17. INFORMANT Address: Springfield Hosp. records, Sykesville, Md.				

MEDICAL CERTIFICATION

1B. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Congestive Heart Failure

DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerotic Heart Disease

DUE TO, OR AS A CONSEQUENCE OF (c): Diabetes Mellitus

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 2509 260 x

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Chronic brain syndrome associated with cerebral arteriosclerosis with psychotic reaction.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County Stote	

22a. **I certify** that I (this hospital) attended the deceased from 3/8/ , 1968, to 9/16/ , 1968, that I (we) last saw the deceased alive on 9/16/ 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) (did not) view the body after death.

22b. SIGNATURE: Gracito V. Patricio	DEGREE: ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]	22c. DATE SIGNED: 9/16/68	
22d. PHYSICIAN'S NAME (Type): GRACITO V. PATRICIO	22e. ADDRESS: Springfield State Hospital Sykesville, Maryland		

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: 9-19-68	23c. NAME OF CEMETERY OR CREMATORY: ASH Memorial Cem.	23d. LOCATION (City or Town): Sandy Spring	(County): Monty	(State): Md.
24. FUNERAL DIRECTOR: George L. Snowden	ADDRESS: Rockville Md.	25a. REC'D BY REGISTRAR DATE: SEP 24 1968	25b. REGISTRAR'S SIGNATURE: J. Charles Judge		

VR A15 (4)
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12796 — 12806

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 30M REV. 1/68

1. DECEASED-NAME (Type or print)	First: James	Middle: Oliver	Last: Hughes, SR.	2a. DATE OF DEATH Month: Sept. Day: 19, Year: 1968	2b. HOUR: 3:45 P.M.	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: Dec. 7, 1900	6. AGE (In years last birthday): 67 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country): Md.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Carroll Md.			
10. CITY OR TOWN OF DEATH: Sykesville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Church St.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Steel Worker	12b. KIND OF BUSINESS OR INDUSTRY: Construction			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Carroll	13c. CITY OR TOWN: Sykesville	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER: Church Street		
14. FATHER'S NAME First: W M	Middle: Burgess	Last: Hughes	15. MOTHER'S MAIDEN NAME First: Ninashan	Middle:	Last: Sellman	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No	(If yes give war or dates of service): —	16b. SOCIAL SECURITY NO.: 213-01-1088	17. INFORMANT Address: Mrs. Bedella Hughes - Sykesville, Md.			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) LEFT VENTRICULAR FAILURE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.
185 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC CA. LIVER + LUNG. — 1 mos.
DUE TO, OR AS A CONSEQUENCE OF (c) CARCINOMA PROSTATE — 1 YR.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
177 X

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (this hospital) attended the deceased from MAR, 19 65, to 9-19, 19 68, that (I) (we) last saw the deceased alive on 9-19 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: R. V. Hough M.D. DEGREE — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22c. DATE SIGNED: 9-20-68

22d. PHYSICIAN'S NAME (Type): R. V. Hough, Jr. — 22e. ADDRESS: Sykesville Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 9-23-68	23c. NAME OF CEMETERY OR CREMATORY: Lake View Cemetery	23d. LOCATION (City or Town): Sykesville, Md.	(County) (State)
24. FUNERAL DIRECTOR: Harry W. Haight	ADDRESS: Sykesville, Md.	25a. REC'D BY REGISTRAR DATE: SEP 24 1968	25b. REGISTRAR'S SIGNATURE: J. Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12797 — 12807

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires thot the deoth certificate be executed within 24 hours after death. Page 4 moy be retained by the haspitol or attending physicion.

TO FUNERAL DIRECTOR: After this certificate has been signed by the ottending physician and completely filled in by the funeral director, page 3 should be detached for use os the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in ony event, within 72 hours after deoth.

1. DECEASED-NAME (Type or print)	First: GEORGE	Middle: BUCHER	Last: JOHN	2a. DATE OF DEATH Month: 9	Day: 1	Year: 68	2b. HOUR: 850 P M
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: JULY 1, 1895	6. AGE (In years last birthday): 73 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.		
7a. BIRTHPLACE (State or foreign country): VIRGINIA	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: CARROLL CO. Md.				
10. CITY OR TOWN OF DEATH: WESTMINSTER	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): CARROLL CO. GEN. HOSP.	12a. USUAL OCCUPATION (Kind of work done during mast of working life, even if retired.): FARMER AND SURVEYOR	12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: CARROLL	13c. CITY OR TOWN: WESTMINSTER	13d. INSIDE CITY LIMITS? YES ☑ NO ☐	13e. STREET AND NUMBER: 59 GREEN ST.			
14. FATHER'S NAME First: JOHN	Middle: JAY	Last: JOHN	15. MOTHER'S MAIDEN NAME First: SARAH	Middle:	Last: BUCHER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): NO	(If yes give war or dates of service): —	16b. SOCIAL SECURITY NO.: 215-32-7189	17. INFORMANT: MRS. EDNA G. JOHN,	Address: SAME ADDRESS			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ACUTE MYOCARDIAL INFARCTION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 24 HOURS
4109
Conditians, if any, which gove rise to immediate cause (a), stating the underlying couse last.
DUE TO, OR AS A CONSEQUENCE OF
(b): ATHEROSCLEROTIC HEART DISEASE — YEARS
DUE TO, OR AS A CONSEQUENCE OF
(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (this hospital) attended the deceased from 8/1, 1968, ta _____, 19____, that (I) (we) last saw the deceased alive an 9/1 1968, and that in (my) (aur) apinian death accurred an the date and haur and fram the causes stated abave. (I) (we) (did) (did nat) view the bady after death.

22b. SIGNATURE: Vincent J. Ficco Jr. M.D.	DEGREE: ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 9/1/68	
22d. PHYSICIAN'S NAME (Type): VINCENT J. FICCO JR.	22e. ADDRESS: ANCHOR ST. WESTMINSTER, MD.		

23a. BURIAL, CREMATION, REMOVAL (Specify): CREMATION	23b. DATE: SEPT. 3, 1968	23c. NAME OF CEMETERY OR CREMATORY: FORT LICOLN CREMATORY	23d. LOCATION (City or Town): BLADENSBURG	(County): (State): MD.
24. FUNERAL DIRECTOR: J. S. Myers Jr., Westminster, Md.	ADDRESS	25a. REC'D BY REGISTRAR DATE: SEP 4 1968	25b. REGISTRAR'S SIGNATURE: J. Charles Judge	

VR A 15 (4)
30M REV. 1-68

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form ANS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12798

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12808

1. DECEASED-NAME (Type or Print) First: BRENDA	Middle: LOUISE	Last: JONES	2a. DATE KNOWN OF DEATH ESTIMATED ☐ Month: 9 Day: 9 Year: 1968	2b. HOUR: 4:31 P.M.			
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: Dec. 19, 1962	6. AGE (In years last birthday): 5 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	2c. DATE PRONOUNCED DEAD Month: 9 Day: 9 Year: 1968	2d. HOUR: 5:30 P.M.		
7a. BIRTHPLACE (State or foreign country): Texas	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Carroll Md.				
10. CITY OR TOWN OF DEATH: Sykesville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Freedom Ave.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Student	12b. KIND OF BUSINESS OR INDUSTRY: —				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Carroll	13c. CITY OR TOWN: Sykesville	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER: Freedom Ave.			
14. FATHER'S NAME First: EVAN	Middle: Jones	Last: III	15. MOTHER'S MAIDEN NAME First: Ocie	Middle: M.	Last: Archer		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT: Mr. Evan Jones III	ADDRESS: Sykesville, Md.				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Fractured Skull (Basilar) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 814.7

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): 8124

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. 4:31 P.M. 9-9 1968	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.): Struck by auto.
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.): Street	21f. LOCATION Street or R.F.D. No.: Freedom Ave. City or Town: Sykesville County: Carroll State: Md.

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: W. Glenn Speicher M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED: 9/9/68

EXAMINER'S NAME (Type): W. Glenn Speicher

ADDRESS (Street, No., Town, or County): 135 E. Main St. Westminster Carroll Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County)
BURIAL	9-12-68	Druid Ridge Cemetery	Pikesville Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Harry W. Wright	Sykesville, Md.	SEP 13 1968	J. Charles Judge

VR A15M8-15
10M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12799 12809

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the deoth certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funerol director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removol, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
PAULA	A. (illegible)	JORDAN	SEPTEMBER 15, 1968	2:40 A M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Female	White	5/14/1897	71 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Germany	U.S.A.	Sep	Carroll Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Sykesville	Springfield State Hospital	Housewife	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Baltimore City	Baltimore	YES X NO	Not known where she resided prior to admission

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Albert		Gessing	Sophie		Buettner

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
No	220-54-7127	Records, Springfield State Hospital

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute peritonitis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Days

DUE TO, OR AS A CONSEQUENCE OF

(b) Perforated acute gangrenous appendix — Days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 5400 5501

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Schizophremic reaction, hebephrenic type

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES X NO	Yes

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

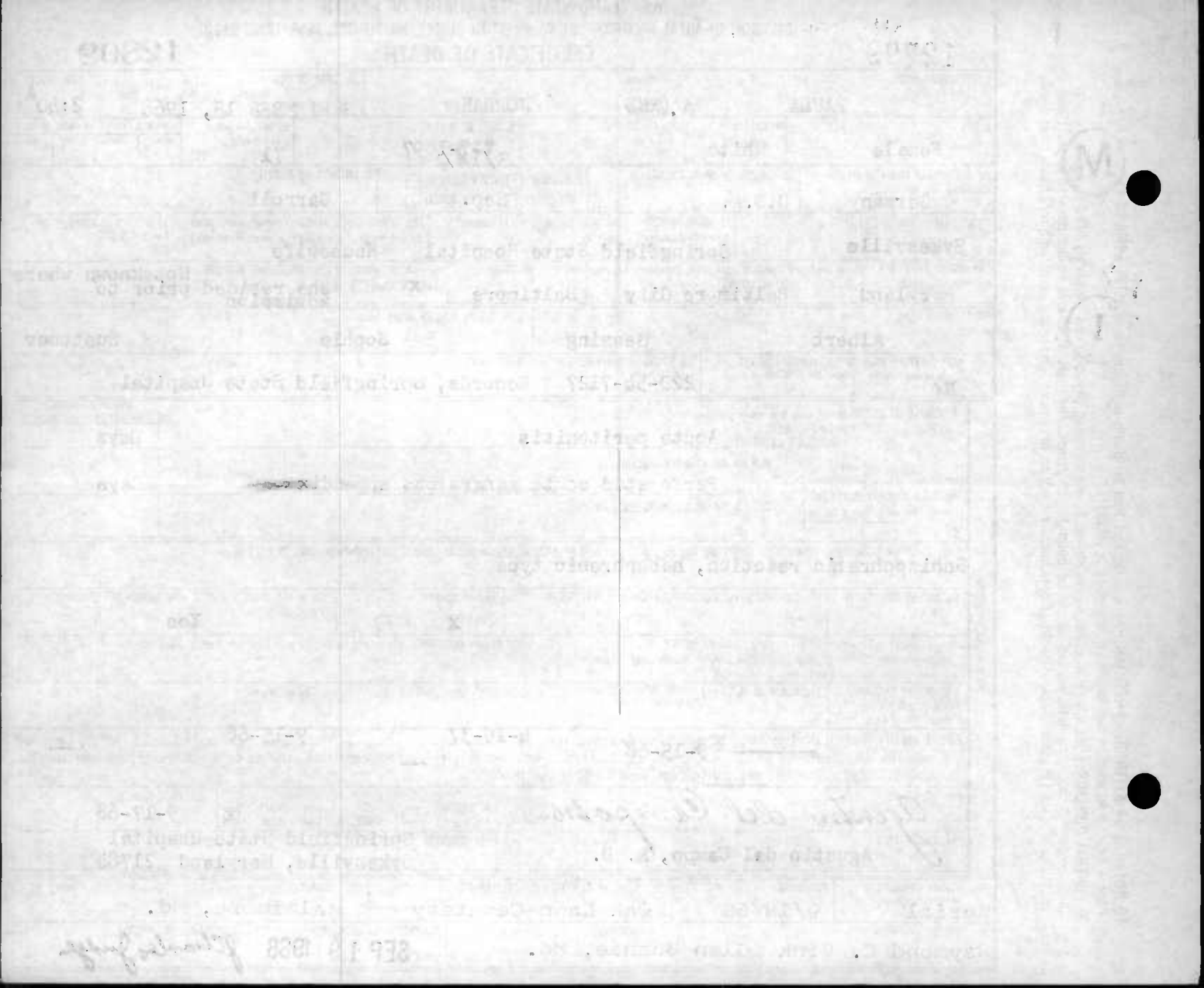
22a. I **certify** that (I) (this hospital) attended the deceased from 4-15-37, 19____, to 9-15-68, 19____, that (I) (we) last saw the deceased alive on 9-15-68 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Agustin del Campo MD		☐	☐	X	9-17-68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Agustin del Campo, M. D.	Springfield State Hospital Sykesville, Maryland 21784

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	9/18/68	Oak Lawn Cemetery	Baltimore, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Raymond C. Fink Glen Burnie, Md.	SEP 19 1968	J. Charles Judge



10 1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12800 12810

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 15(4)
30M REV 1/68

1. DECEASED-NAME (Type or print) First: Virginia	Middle:	Last: Julia	2a. DATE OF DEATH Month: Sept	Day: 5	Year: 1968
2b. HOUR: 10:15 PM					
3. SEX: female	4. RACE: White	5. DATE OF BIRTH: March 24 - 1912	6. AGE (In years last birthday): 56 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): Washington D.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐	9. COUNTY OF DEATH: Carroll Md.		
10. CITY OR TOWN OF DEATH: Manchester	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Long View Nursing Home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Statistical Asst	12b. KIND OF BUSINESS OR INDUSTRY: govt.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: MONTGOMERY	13c. CITY OR TOWN: Bethesda	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 5209 Acacia ave.	
14. FATHER'S NAME First: Arthur	Middle: W	Last: Sharrer	15. MOTHER'S MAIDEN NAME First: Alberta	Middle: Irene	Last: Selby
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 216-44-6900	17. INFORMANT: Robert Julia	Address: 59 Penna ave Westminster md		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Vascular Accident — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 weeks
437.9
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Cerebral Arteriosclerosis Type with brain atrophy
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
331X Bronchopneumonia

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (this hospital) attended the deceased from 8/19, 1968, to 9/5, 1968, that (I) (we) last saw the deceased alive on 9/4, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: W H Foard M.D	DEGREE	ATTENDING PHYS. ☑	MED. DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED: 9/5/68
22d. PHYSICIAN'S NAME (Type): W. H Foard M.D	22e. ADDRESS: Manchester, md 21102				

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: Sept. 9, 1968	23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery	23d. LOCATION (City or Town) (County) (State): Suitland, Md.	
24. FUNERAL DIRECTOR: JOSEPH GAWLER SONS, INC.	ADDRESS: 5130 Wisconsin Ave. NW. Washington, D. C.	25a. REC'D BY REGISTRAR DATE: SEP 11 1968	25b. REGISTRAR'S SIGNATURE: Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12801 — 12811

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: F.	Middle: EDNA	Last: KEEFER	2a. DATE OF DEATH Month: 9	Day: 10	Year: 68
2b. HOUR: 11A M						
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: Oct. 4, 1885	6. AGE (In years last birthday): 82 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Carroll Md.			
10. CITY OR TOWN OF DEATH: Westminster	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Carroll Co. Gen. Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife	12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Carroll	13c. CITY OR TOWN: Westminster	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER: Route 5		
14. FATHER'S NAME First: David	Middle:	Last: Zile	15. MOTHER'S MAIDEN NAME First: Annie	Middle:	Last: Zile	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 220-34-7225	17. INFORMANT: Mrs. Annie Lambert	Address: Same As #13			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CHRONIC LYMPHOCYTIC LEUKEMIA — MONTHS

DUE TO, OR AS A CONSEQUENCE OF

(b):

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. 2041 2040

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

ARTERIOSCLEROTIC HEART DISEASE - DECOMPENSATED

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 9/9, 1968, to 9/10, 1968, that (I) (we) last saw the deceased alive an 9/10 1968, and that in (my) (aur) apinian death accurred an the date and haur and from the causes stated abave, (I) (we) (did) (did nat) view the bady after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Vincent J Fiocco	M.D.	☑	☐	☐	9/10/68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Vincent Fiocco	Westminster, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	9/13/1968	Ebenezer Cemetery	Winfield Carroll Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
C. M. Waltz, Box 241, Sykesville, Md.	SEP 13 1968	J. Charles Jones

VR A13(4) 30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12802 — 12812

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR	
Ignatius	Loyola	Kenney	September 2, 1968	6:30 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Male	White	10/4/08	59 YRS.		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH		
Maryland	U.S.A.	Separated	Carroll County, Md.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY		
Sykesville	Springfield State Hospital	Pianist			
13a. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER	
Maryland	Allegany	Frostburg		86 West Main Street	
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last			
James Patrick Kenney		Mary Elizabeth Caunihan			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address		
No	-	216-22-6082	Records, Springfield State Hospital		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: days
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 485 x 491 x

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Psychosis with convulsive disorder, epileptic clouded state

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that (I) (this hospital) attended the deceased from 7/26/47, 19____, to 9/2/68 19____, that (I) (we) last saw the deceased ~~alive~~ on 9/2/68 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED	
[signature]	ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒	9-2-66	6:30 p.m.
22d. PHYSICIAN'S NAME (Type) ISAK E. HAPNER, M.D.		22e. ADDRESS Springfield State Hospital	

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	9/5/1968	Sunset Memorial Park	Near Cumberland Alleg Md
24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
John J. Stafford, Jr. Funeral Home	1230 Balto Ave Cumberland, Md	SEP 9 1968	J. Charles Judge

VR A15 (4) 30M REV. 7-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12802 — 12813

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 15 (4) 30M REV. 11-68

1. DECEASED-NAME (Type or print) First: Nellie	Middle: P.	Last: Kenney	2a. DATE OF DEATH Month: 9 Day: 13 Year: 68
2b. HOUR: 7:25 P.M.			
3. SEX: female	4. RACE: white	5. DATE OF BIRTH: Sept. 23, 1889	6. AGE (In years last birthday): 78 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Carroll Md.
10. CITY OR TOWN OF DEATH: Sykesville-Rural	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Springfield Hosp.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: Own Home
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Allegany ✓	13c. CITY OR TOWN: Cumberland	13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: 211 Maryland Ave.			
14. FATHER'S NAME First: Jacob	Middle: C.	Last: Burns	15. MOTHER'S MAIDEN NAME First: Mary	Middle: C.	Last: Gaver
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No	16b. SOCIAL SECURITY NO.: None	17. INFORMANT Address: Springfield Hosp. Records; Sykesville, Md.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute myocardial infarction. — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: hours

DUE TO, OR AS A CONSEQUENCE OF

(b) Congestive heart fialure. — hours

DUE TO, OR AS A CONSEQUENCE OF

(c) Arteriosclerotic cardio-vascular disease. — years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Chronic Brain Syndrome Associated with Cerebral Arteriosclerosis with psychotic reaction

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. **I certify** that (I) (this hospital) attended the deceased from 10-28, 19 66, to 9-13, 19 68, that ~~I~~ (we) last saw the deceased alive on 9-13 19 68, and that in (~~my~~) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (~~did not~~) view the body after death.

22b. SIGNATURE: Paul G. Ensor	DEGREE: ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☑	22c. DATE SIGNED: 9-13-68	
22d. PHYSICIAN'S NAME (Type): Paul G. Ensor, M.D.	22e. ADDRESS: Springfield State Hospital Sykesville, Maryland		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: Sept. 16, 1968	23c. NAME OF CEMETERY OR CREMATORY: St. Patrick Catholic	23d. LOCATION (City or Town) (County) (State): Cumberland Allegany Md.	
24. FUNERAL DIRECTOR: Wright Funeral Home Byron Wright	ADDRESS: Cumberland, Md.	25a. RECD BY REGISTRAR DATE: SEP 18 1968	25b. REGISTRAR'S SIGNATURE: Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12804

CERTIFICATE OF DEATH

12814

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Lillian	(none)	LONG	Sept 2 1968	6:05 P.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Female	Cauc.	27 Nov 1900	67 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Balto. City	U.S.	MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	CARROLL Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Westminster	Rt. 4 Box 312A	HOUSE-WIFE	—

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	CARROLL	Westminster	YES ☐ NO ☒	Rt. #4 Box 312A

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Noah	Wesley	Dies	Mabel		Dies

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
NO	217-05-[illegible]	Husband	Same

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF
(b) ASCVD
DUE TO, OR AS A CONSEQUENCE OF
(c)

4109
Conditions, if ony, which gove rise to immediote couse (a), stoting the underlying couse last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 Hepatoma

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
July 68	Abdominal Anasis	YES ☐ NO ☒	

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED While ot work ☐ Not while ot work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from July, 1967, to Aug, 1968, that (I) (we) last saw the deceased alive on July 1968, and that it (my) (our) apinian death occurred on the date and haur and from the causes stated abave, (I) (we) (did) (did nat) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Dean H. Griffin	M.D.	☒	☐	☐	2 Sept 68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Dean H. Griffin M.D.	19 Ridge Rd., Westminster, md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	9/5/68	WESTMINSTER CEMETERY	WESTMINSTER, MD

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
J. S. Myers, Jr., Westminster, md.	SEP 4 1968	J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

12805 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12815

1. DECEASED-NAME (Type or Print) First: FREDERICK	Middle: EMMETT	Last: LORD	2a. DATE KNOWN OF DEATH ☒ ESTIMATED ☐ Month: 9 Day: 20 Year: 1968	2b. HOUR: 11:00 A.M.	
3. SEX: MALE	4. RACE: White	5. DATE OF BIRTH: Aug. 12, 1898	6. AGE (In years last birthday): 70 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	2c. DATE PRONOUNCED DEAD Month: 9 Day: 20 Year: 1968	2d. HOUR: 3:30 P.M.
7a. BIRTHPLACE (State or foreign country): Md.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Carroll Md.		
10. CITY OR TOWN OF DEATH: Woodbine	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Woodbine Road	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Carpenter	12b. KIND OF BUSINESS OR INDUSTRY: Building		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Carroll	13c. CITY OR TOWN: Sykesville	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER: Liberty Road	
14. FATHER'S NAME First: Emmett	Middle: -	Last: Lord	15. MOTHER'S MAIDEN NAME First: Rosie	Middle: -	Last: Weaver
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 219-12-7037	17. INFORMANT: Mrs Edith Lord	ADDRESS: Sykesville, Md.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarct (Acute)
DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerosis Dis
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4109
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
4201

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒
21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: W. Glenn Speicher M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22b. DATE SIGNED: 9-20-68
EXAMINER'S NAME (Type): W. Glenn Speicher
ADDRESS (Street, city, town, or county): 135 E. Main Westminster, Carroll Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: 9-23-68	23c. NAME OF CEMETERY OR CREMATORY: Lorraine Cemetery	23d. LOCATION (City or Town): Baltimore (County) Md. (State)	
24. FUNERAL DIRECTOR: Harry W. Haight	ADDRESS: Sykesville, Md.	25a. REC'D BY REGISTRAR DATE: SEP 24 1968	25b. REGISTRAR'S SIGNATURE: J. Charles Judy	

VR A15ME (5) 10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12806 — 12816

1. DECEASED-NAME (Type or print): First: Sterling; Middle: E.; Last: Mathias
2a. DATE OF DEATH: Month 9; Day 9; Year 68
2b. HOUR: 11:00 P.M.
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH: 5/2/1899
6. AGE (In years last birthday): 69 YRS. IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (State or foreign country): Carroll Co. Md.
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. COUNTY OF DEATH: Carroll Md.
10. CITY OR TOWN OF DEATH: Westminster
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Carroll Co. General Hospital
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Retired Canner
12b. KIND OF BUSINESS OR INDUSTRY: Cannery
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland
13b. COUNTY: Carroll
13c. CITY OR TOWN: Westminster
13d. INSIDE CITY LIMITS? YES [ ] NO [X]
13e. STREET AND NUMBER: R. D. 2
14. FATHER'S NAME: First J.; Middle Grant; Last Mathias
15. MOTHER'S MAIDEN NAME: First Lizzie; Middle -; Last Armacost
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No.
16b. SOCIAL SECURITY NO.: 218-12-7177
17. INFORMANT: Address: Erma M. Mathias, Westminster, Md. R.D.2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 7 DAYS
DUE TO, OR AS A CONSEQUENCE OF
(b) ARTERIOSCLEROTIC HEART DISEASE — YEARS
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 BRONCHOPNEUMONIA

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES [ ] NO [ ]
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 9/2, 1968, to 9/9, 1968, that (I) (we) last saw the deceased alive on 9/9 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Vincent J. Kroos Jr MD — DEGREE — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22c. DATE SIGNED: 9/9/68
22d. PHYSICIAN'S NAME (Type)
22e. ADDRESS: Westminster, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 9/12/68
23c. NAME OF CEMETERY OR CREMATORY: Kriders Cemetery
23d. LOCATION (City or Town) (County) (State): Nr. Westminster, Carroll Co. Md.
24. FUNERAL DIRECTOR: Richard A. Little
ADDRESS: Littlestown, Pa.
25a. REC'D BY REGISTRAR DATE: SEP 13 1968
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1502
30M REV 7/68

No. 216-12-7177 Erma M. Hutchins, Westminster, Md. U.S.A.

1. Front Matches Little - Annapost

Main/Hand Carroll Westminster * M. D. &

Westminster Carroll Co. General Hospital, retired Chemist Chemistry

Carroll Co., Md. U.S.A. Carroll

Male White 5/2/1899 09

Burial 9/12/09 Antietam Cemetery Mr. Westminster, Carroll Co.,

Hutchinson, Pa.

Westminster, Md.

p 3 1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12807 — 12817

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Lavinia	Elizabeth	Muehlberger	9	5	68	2:05 pm M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
female	white	8/29/86	82 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
Penna.	USA		Carroll Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Rural--Sykesville	Springfield State Hospital	winder-silk mill	Silk Mill

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	—	Baltimore	YES ☒ NO ☐	1310 Pentwood Road

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
William		Behney	Nancy		Unk. ?

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
no	187-07-2549-A	Springfield Hospital records, Sykesville, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Congestive heart failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: hours

DUE TO, OR AS A CONSEQUENCE OF

(b) Bilateral pneumonitis — days

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 486X 490X

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Chronic brain syndrome with senile brain disease with psychotic reaction.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I certify thot ☒ (this hospital) attended the deceased from 8/17/66, to 9/5/68, thot ☒ (we) lost sow the deceased alive on 9/5/68, and that in (my) (aur) opinion deoth occurred an the date and haur and from the couses stated above, ☒ (we) (did) ~~did not~~ view the body after deoth.

22b. SIGNATURE Renato R. Espina, M.D. DEGREE — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒ — 22c. DATE SIGNED 9/5/68

22d. PHYSICIANS NAME (Type) Renato R. Espina, M. D. — 22e. ADDRESS Springfield State Hospital Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	9-9-68	Hillside	Allentown Pa.

24. FUNERAL DIRECTOR	ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Luther A. Haight	Sykesville, Md.	SEP 10 1968	J. Charles Judge

VR A15 (4)
30M REV. 1/68

1

FOR STATE HEALTH DEPT.

12808

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12818

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) First	Middle	Last	2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ Month Day Year	2b. HOUR
MAGGIE	ALICE	PEARL	9-25 1968	9:20 A M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	2c. DATE PRONOUNCED DEAD Month Day Year	2d. HOUR
Female	White	1-4-1883	85 YRS.			SEPTEMBER 25 1968	9:20 A M

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
Pennsylvania	U.S.A.		Carroll Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Sykesville	Springfield State Hospital	Domestic	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Washington	Williamsport	YES ☐ NO ☒	Rt. 1, Box 210

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Robert		Brown	Susan		Lisbon

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	220-54-6283J1	Records, Springfield State Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Heart Failure	days/weeks
DUE TO, OR AS A CONSEQUENCE OF	Coronary arteriosclerosis and Mitral Valve insufficiency	4 years years
(b) DUE TO, OR AS A CONSEQUENCE OF		
(c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4129 4201

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Recent fracture of left femur

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
	3:20 xx 9-21-1968	Fell while coming from bathroom.

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State
	Springfield State Hospital	H Ward, Warfield Division, Sykesville, Maryland Carroll

22a. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE W. Glenn Speicher M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED 9-25-68

EXAMINER'S NAME (Type) W. Glenn Speicher, M. D.

ADDRESS (Street, No., Town, or County) P.O. Sykesville Carroll Co. Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Sept. 28, 1968	Riverview Cemetery	Williamsport Washington Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
ALBERT L. LEAF WILLIAMSPORT, Md.	SEP 30 1968	J. Charles Jugga

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death unless any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12809 Item#1, FilmG405 10/3/68 km

12819

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 30M REV. 1-68

1. DECEASED-NAME (Type or print)	First: CALVIN	Middle: LEROY Lenox	Last: REISINGER	2a. DATE OF DEATH Month: 9 Day: 27 Year: 68	2b. HOUR: 1:35 PM
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: 3-2-1880 (1880)	6. AGE (In years last birthday): 88 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Carroll Md.		
10. CITY OR TOWN OF DEATH: Sykesville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Springfield State Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): R.R. Clerk (Retired)	12b. KIND OF BUSINESS OR INDUSTRY:		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Baltimore City	13c. CITY OR TOWN: Baltimore	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 310 W. 31st Street	
14. FATHER'S NAME First: Unk.	Middle:	Last:	15. MOTHER'S MAIDEN NAME First: Unk.	Middle:	Last:
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 212-07-7677A	17. INFORMANT: Records, Springfield State Hospital	Address:	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Diabetic acidosis — Approximate interval between onset and death: Days

DUE TO, OR AS A CONSEQUENCE OF

(b): Diabetes — Years

DUE TO, OR AS A CONSEQUENCE OF

(c): Generalized arteriosclerosis — Years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 2509

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 260X

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (this hospital) attended the deceased from 9-14-68, 19____, to 9-27-68, 19____, that (I) (we) last saw the deceased alive on 9-27-68 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Paul G. Ensor M.D. DEGREE — ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]

22c. DATE SIGNED: 9/27/68

22d. PHYSICIAN'S NAME (Type): Paul G. Ensor, M. D.

22e. ADDRESS: Springfield State Hospital Sykesville, Maryland 21784

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 9-30-68	23c. NAME OF CEMETERY OR CREMATORY: Loudon Park	23d. LOCATION (City or Town): Baltimore	(County): (State): Md.
24. FUNERAL DIRECTOR: Harry W. Haight	ADDRESS: Sykesville, Md.	25a. REC'D BY REGISTRAR DATE: OCT 2 1968	25b. REGISTRAR'S SIGNATURE: J. Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12810 — 12820

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: John	Middle: Dean	Last: Reister	2a. DATE OF DEATH: Month Sept	Day 16,	Year 1968	2b. HOUR: 9 A M
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: Aug 26,05	6. AGE (In years last birthday): 63 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.		
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Carroll County Md.				
10. CITY OR TOWN OF DEATH: Westminister Md.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Carroll Co. General Hospt	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Security Guard	12b. KIND OF BUSINESS OR INDUSTRY: Aircraft Cookysville				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md	13b. COUNTY: Balto.	13c. CITY OR TOWN: Reisterstown	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 313 Highmeadow Rd.			
14. FATHER'S NAME First: John Dean Reister	Middle	Last	15. MOTHER'S MAIDEN NAME First: Birdie	Middle	Last: Keller		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): Unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 213-05-3424	17. INFORMANT: Mrs. Margaret Reister	Address: Reisterstown 313 Highmeadow Rd				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): 519.2

Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Chronic obstructive Pulmonary Disease

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): 527.2

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [X] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, natify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Nat while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that (I) (this hospital) attended the deceased from Sept 7, 1968, to Sept 16, 1968, that (I) (we) lost saw the deceased olive on Sept 16, 1968, and that in (my) (aur) apinian death accurred on the date and hour and from the causes stoted above, (I) (~~are~~) (did) (~~didnot~~) view the body after deoth.

22b. SIGNATURE: John S. Harshey, M.D. DEGREE	ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]	22c. DATE SIGNED: 9/16/68	
22d. PHYSICIAN'S NAME (Type): JOHN S. HARSHEY, M.D.	22e. ADDRESS: 8 Arch St. Westminster, Md		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: Sept. 19,68	23c. NAME OF CEMETERY OR CREMATORY: Woodlawn Cemetery	23d. LOCATION (City or Town) (County) (State): Woodlawn Balto. Co. Md.	
24. FUNERAL DIRECTOR: Loring Byers	ADDRESS: 8728 Liberty Rd. Randallstown	25a. REC'D BY REGISTRAR DATE: SEP 18 1968	25b. REGISTRAR'S SIGNATURE: J. Charles Judge	

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12821

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 30M REV. 1-68

1. DECEASED-NAME (Type or print)	First: Walter	Middle: W.	Last: Rhoten
2a. DATE OF DEATH	Month: September	Day: 14,	Year: 1968
2b. HOUR	9:30pM		
3. SEX	Male		
4. RACE	White		
5. DATE OF BIRTH	January 20, 1899		
6. AGE (In years last birthday)	69 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country)	Maryland		
7b. CITIZEN OF WHAT COUNTRY?	U. S. A.		
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]			
9. COUNTY OF DEATH	Carroll Md.		
10. CITY OR TOWN OF DEATH	Hampstead, Maryland		
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	35 South Main Street		
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	Laborer mechanic		
12b. KIND OF BUSINESS OR INDUSTRY	Auto Ind.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	Maryland		
13b. COUNTY	Carroll		
13c. CITY OR TOWN	Hampstead,		
13d. INSIDE CITY LIMITS? YES [X] NO [ ]			
13e. STREET AND NUMBER	35 South Main Street		
14. FATHER'S NAME	First: James	Middle: E.	Last: Rhoten
15. MOTHER'S MAIDEN NAME	First: Sadie	Middle: Virginia	Last: Wilhelm
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	No		
16b. SOCIAL SECURITY NO.	215-07-4833		
17. INFORMANT	Nettie Rhoten	Address: Hampstead, Maryland	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Heart Disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 10 yrs.
DUE TO, OR AS A CONSEQUENCE OF
(b) Arteriosclerotic Cardio Vascular Disease
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last. 4129 4201

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Diabetes Mellitus

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
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21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (this hospitol) ottended the deceosed from October 13, 1956, to Sept. 14, 1968 that (I) (we) last saw the deceased olive an August 30, 1968, ond thot in (my) (our) opinion deoth occurred on the dote ond hour and from the causes stated obave, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE (DEGREE)	ATTENDING PHYS. [X]	MED. DIRECTOR [ ]	STAFF PHYS. [ ]
22c. DATE SIGNED	9/14/68		
22d. PHYSICIAN'S NAME (Type)	Joseph E. Bush M. D.		
22e. ADDRESS	35 South Main Street, Hampstead, Md.		

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County) (State)
Burial	Sept. 18, 1968	Hampstead Cemetery	Hampstead	Carroll CO. Md.

24. FUNERAL DIRECTOR ADDRESS	Tipton - Eline Funeral Home Hampstead, Md.	25a. REC'D BY REGISTRAR DATE	SEP 20 1968
25b. REGISTRAR'S SIGNATURE	J. Charles Jusge		

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 2 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MV3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

12812 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12822

1. DECEASED-NAME (Type or Print) First: WILLIAM	Middle: HARRISON	Last: SAUBLE	2a. DATE KNOWN OF DEATH ☒ ESTIMATED ☐ Month: 9 Day: 26 Year: 1968	2b. HOUR 6:00 P M	
3. SEX: M	4. RACE: W	5. DATE OF BIRTH: OCT 4 1895	6. AGE (In years last birthday) 72 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	2c. DATE PRONOUNCED DEAD Month: 9 Day: 26 Year: 1968	2d. HOUR 6:35 P M
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: CARROLL Md.		
10. CITY OR TOWN OF DEATH: UNION BRIDGE	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): ROUTE 1	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): FARMER	12b. KIND OF BUSINESS OR INDUSTRY: FARM		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MD	13b. COUNTY: CARROLL	13c. CITY OR TOWN: UNION BRIDGE RURAL	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER: NONE	
14. FATHER'S NAME First: WILLIAM	Middle:	Last: SAUBLE	15. MOTHER'S MAIDEN NAME First: LAURA	Middle:	Last: GRIFFIN
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 218-40-4906	17. INFORMANT: RUBY SAUBLE	ADDRESS: UNION BRIDGE RI MD		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis (acute) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO, OR AS A CONSEQUENCE OF
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒
21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: W Glenn Speicher — CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type): W GLENN SPEICHER — ADDRESS (Street or R.F.D., City or County): 135 E Main St Westminster Carroll MD

22b. DATE SIGNED: 9-26-68

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: 9/29/1968	23c. NAME OF CEMETERY OR CREMATORY: PIPE CREEK	23d. LOCATION (City or Town) (County) (State): NEW WINDSOR RURAL MD	
24. FUNERAL DIRECTOR: D D Hartzler & Sons	ADDRESS: Union Bridge	25a. REC'D BY REGISTRAR DATE: SEP 30 1968	25b. REGISTRAR'S SIGNATURE: J Charles Judge	

VR A15ME (5)
10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12813 12823

1. DECEASED-NAME (Type or print): First JOHN Middle JOSEPH Last SCHULTZ
2a. DATE OF DEATH: Month SEPT. Day 2 Year 1968
2b. HOUR: 12:45 P.M.
3. SEX: MALE
4. RACE: WHITE
5. DATE OF BIRTH: APRIL 23, 1879
6. AGE (In years last birthday): 89 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (State or foreign country): AUSTRIA-HUGRIA
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. COUNTY OF DEATH: CARROLL Md.
10. CITY OR TOWN OF DEATH: SYKESVILLE
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): FULLEN NURSING HOME
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): INSTRUMENT MAKER
12b. KIND OF BUSINESS OR INDUSTRY: BUREAU OF MINES
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md
13b. COUNTY: BALTIMORE
13c. CITY OR TOWN: RANDALLSTOWN
13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET AND NUMBER: 3415 OFFUTT ROAD,
14. FATHER'S NAME First KARL Middle SCHULTZ Last
15. MOTHER'S MAIDEN NAME First ANNA Middle JAROLIMEK Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: N/O (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.: 179-36-1831
17. INFORMANT: MRS ANNE WEBER Address: 3415 OFFUTT ROAD RANDALLSTOWN

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremic Coma — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 wks.
403 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF (b) Nephrosclerosis — 3 months
DUE TO, OR AS A CONSEQUENCE OF (c) Gen. ART.SCL — 10 Yrs.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
446X

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES [ ] NO [ ]
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County Stote

22a. I certify that (I) (this hospital) attended the deceased from 12/12, 19 66, to 9/1, 19 68, that (I) (we) last saw the deceosed olive on 9/1 19 68, and that in (my) (aur) apinion death occurred on the dote and hour and from the couses stoted obove, (I) (we) (did) (did not) view the body ofter deoth.

22b. SIGNATURE: Sani Okutman DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22c. DATE SIGNED: 9/3/68
22d. PHYSICIAN'S NAME (Type): Sani Okutman, M.D.
22e. ADDRESS: Obrecht Rd., Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 9-5-68
23c. NAME OF CEMETERY OR CREMATORY: Lake View
23d. LOCATION (City or Town) (County) (State): Sykesville, Carroll, Md.
24. FUNERAL DIRECTOR: Luther A. Haight ADDRESS: Sykesville, Md.
25a. REC'D BY REGISTRAR DATE: SEP 10 1968
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires thot the death certificate be executed within 24 hours after death. Page 4 moy be retoined by the hospitol or attending physicion.

TO FUNERAL DIRECTOR: After this certificate hos been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use os the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12814 — 12824

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: Margarette	Middle: Louise	Last: Schwinger	2a. DATE OF DEATH: Month September Day 24, Year 1968	2b. HOUR: 11:00 A
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: 9-20-04	6. AGE (In years last birthday): 64 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): Penna.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Carroll County, Md.		
10. CITY OR TOWN OF DEATH: Sykesville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Springfield State Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Domestic	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Washington	13c. CITY OR TOWN: Smithsburg	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER: Route 2	
14. FATHER'S NAME First Middle Last: Charles Schwinger	15. MOTHER'S MAIDEN NAME First Middle Last: Minnie Ott				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: — (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address: Records, Springfield State Hospital			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Bronchopneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Days

DUE TO, OR AS A CONSEQUENCE OF

(b): Arteriosclerotic heart disease — Years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c): Generalized arteriosclerosis — Years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Esophageal stricture----months

Schizophrenic reaction, paranoid type

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. **I certify** that (I) (this hospital) attended the deceased from 11-25-1958, to 9-24-, 1968, that (I) (we) last saw the deceased ~~alive on~~ 9-24-68 19___, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Agustin del Campo M.D. DEGREE — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒	22c. DATE SIGNED: September 24, 1968	
22d. PHYSICIAN'S NAME (Type): Agustin del Campo, M.D.	22e. ADDRESS: Springfield State Hospital	

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 9/27/1968	23c. NAME OF CEMETERY OR CREMATORY: Rose Hill	23d. LOCATION (City or Town) (County) (State): Hagerstown, Washington, Md.	
24. FUNERAL DIRECTOR: Walter J. Grove	ADDRESS: Waynesboro Pa	25a. REC'D BY REGISTRAR DATE: SEP 26 1968	25b. REGISTRAR'S SIGNATURE: J. Charles Judge	

VR A15 (4)
30M REV. 2-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12815

CERTIFICATE OF DEATH

12825

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4-68)
30M REV. 12-68

1. DECEASED-NAME (Type or print) First / Middle / Last	Catherine Claudine Scott	2a. DATE OF DEATH Month Day Year	September 24, 1968	2b. HOUR	5:45 PM
3. SEX	Female	4. RACE	White	5. DATE OF BIRTH	2-3-78
6. AGE (In years last birthday)	90 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country)	Maryland	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	
9. COUNTY OF DEATH	Carroll County, Md.				
10. CITY OR TOWN OF DEATH	Sykesville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	Springfield State Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	Housewife
12b. KIND OF BUSINESS OR INDUSTRY	Home				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	Maryland	13b. COUNTY	Howard	13c. CITY OR TOWN	Sykesville
13d. INSIDE CITY LIMITS? YES ☐ NO ☒		13e. STREET AND NUMBER	Route 32		
14. FATHER'S NAME First / Middle / Last	William T. Burgoon	15. MOTHER'S MAIDEN NAME First / Middle / Last	Anna M. Schaeffer		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	No	16b. SOCIAL SECURITY NO.	unk.	17. INFORMANT Address	Records, Springfield State Hospital

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Squamous cell carcinoma of neck — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: months

DUE TO, OR AS A CONSEQUENCE OF

(b) Bronchopneumonia — days

DUE TO, OR AS A CONSEQUENCE OF

(c) Arteriosclerotic heart disease — years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1734 1904

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) arteriosclerosis CBS, associated with senile brain disease with psychotic reaction, cerebral

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County / State

22a. **I certify** that (I) (this hospital) attended the deceased from 2-24-58 19____, to 9-24-68 19____, that (I) (we) last saw the deceased alive on 9-24-68 19____, and that in (my) (our) opinian death occurred on the date and haur and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE, DEGREE	Agustin del Campo M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒	22c. DATE SIGNED	9-24-68
22d. PHYSICIAN'S NAME (Type)	Agustin del Campo, M.D.	22e. ADDRESS	Springfield State Hospital

23a. BURIAL, CREMATION, REMOVAL (Specify)	Burial	23b. DATE	9-27-68	23c. NAME OF CEMETERY OR CREMATORY: Springfield Cemetery
23d. LOCATION (City or Town) (County) (State)	Sykesville Md			
24. FUNERAL DIRECTOR ADDRESS	Thos. W. Haight Sykesville, Md.	25a. REC'D BY REGISTRAR DATE	SEP 30 1968	25b. REGISTRAR'S SIGNATURE: J. Charles Judge

8 1

12816

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12826

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physicion.

TO FUNERAL DIRECTOR: After this certificate hos been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use os the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

1. DECEASED-NAME (Type or print) First	Middle	Lost	2a. DATE OF DEATH Month Day Year	2b. HOUR
Minnie	Victoria	Skillman	9 5 68	10:45 am

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
female	white	11/28/79	88 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
Penna.	USA		Carroll Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Rural--Sykesville	Springfield State Hospital	housewife	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Montgomery	Gaithersburg	YES ☐ NO ☒	Route #3

14. FATHER'S NAME First	Middle	Lost	15. MOTHER'S MAIDEN NAME First	Middle	Lost
unknown			Francesca		Knauss

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
no	none	Springfield Hospital records, Sykesville, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Broncopneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: days

DUE TO, OR AS A CONSEQUENCE OF

(b) Arteriosclerotic Heart Disease — years

DUE TO, OR AS A CONSEQUENCE OF

(c) Coromary Arteriosclerosis — years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4129 4201

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Chronic brain syndrome with senile brain disease with psychotic reaction.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED While ot work ☐ Not while ot work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.	21f. LOCATION Street or R.F.D. No. City or Town County Stote

22a. **I certify** that ☒ (this hospital) attended the deceased from 7/14/64, to 9/5/68, that ☒ (we) last sow the deceosed olive on 9/5/1968, and that in (my) (our) opinian death occurred on the date ond hour and from the causes stoted obave, ☒ (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Renato R. Espina		☐	☐	☒	9/5/68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Renato R. Espina, M. D.	Springfield State Hospital Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	9-7-68	Darnestown Church Cem.	Darnestown, Maryland

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
ROBERT A. PUMPHREY, Bethesda, Maryland	SEP 10 1968	J. Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12817 12827

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Sarah	Louise	Setdorus	September 7, 1968	2:P M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Female	White	Nov. 8, 1874	93 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
Balto Co. Md.	U.S.A.		Carroll. Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Lineboro	Springville Rd.	Housewife.	Own home

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER
Md.	Carroll	Lineboro		Springville Rd.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
William	Henry	Arthur	Elizabeth		Bailey

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
No		215-56-7431	Mrs. Minnie V.B. Rill	Lineboro Md. R.D.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Congestive heart failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 days,

DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease — 20 yrs,

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4129

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

4200

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
—	—		—

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** thot (I) (this hospitol) ottended the deceased from June, 19 66, to 9/7, 19 68, thot (I) (we) lost sow the deceased olive on 9/8, 19 68, ond thot in (my) (our) opinion deoth occurred on the dote ond hour ond from the couses stoted above, (I) (We) (did) (did not) view the body ofter deoth.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Robert Althard, MD		☒	☐	☐	9/8/68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Robert Althard, MD	14 water St, Glen Rock, Pa

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
Burial	Sept. 10, 1968	Bethlehem Stitz.	Glen Rock,	Pa.	

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
James F. Harlenstein	New Freedom, Pa	SEP 13 1968	J. Charles Judge

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12818 — 12828

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate hos been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or print) First / Middle / Lost	Kathleen Dorothy Spencer			2a. DATE OF DEATH Month / Day / Year	September 13, 1968
				2b. HOUR	9:05 AM
3. SEX	Female	4. RACE	White	5. DATE OF BIRTH	3/24/88
6. AGE (In years last birthday)	80 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country)	New York	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	
9. COUNTY OF DEATH	Carroll County, Md.				
10. CITY OR TOWN OF DEATH	Sykesville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	Springfield State Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	Housewife
12b. KIND OF BUSINESS OR INDUSTRY	HOME				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	Maryland	13b. COUNTY	Montgomery	13c. CITY OR TOWN	Sandy Spring
13d. INSIDE CITY LIMITS? YES [ ] NO [ ]	[X]	13e. STREET AND NUMBER	17401 Norwood Road		
14. FATHER'S NAME First / Middle / Lost	Matthew Fitzgerald	15. MOTHER'S MAIDEN NAME First / Middle / Last	Delia Wallace		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	No	16b. SOCIAL SECURITY NO.	062-09-4827-B	17. INFORMANT Address	Records, Springfield State Hospital

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arteriosclerotic heart disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Years

DUE TO, OR AS A CONSEQUENCE OF

(b) Bronchopneumonia — Days

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4129

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

4200

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Port 2, Item 18.)		
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County / State

22a. I certify thot (I) (this hospitol) attended the deceased from 8/21, 1968, to 9/13, 1968, that (I) (we) last saw the deceased alive on 9/13 1968, and that in (my) (our) opinion death occurred on the date and hour ond from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	Agustin del Campo M.D.	DEGREE	ATTENDING PHYS. [ ]	MED. DIRECTOR [ ]	STAFF PHYS. [X]
22c. DATE SIGNED	9/13/68				
22d. PHYSICIAN'S NAME (Type)	Agustin del Campo, M.D.	22e. ADDRESS	Springfield State Hospital, Sykesville, Md.		

23a. BURIAL, CREMATION, REMOVAL (Specify)	Burial	23b. DATE	9-16-68	23c. NAME OF CEMETERY OR ~~CREMATORY~~	Kensico
23d. LOCATION (City or Town) (County) (State)	Valhalla, New York				
24. FUNERAL DIRECTOR	Luther H. Haight	ADDRESS	Sykesville, Md	25a. REC'D BY REGISTRAR DATE	SEP 19 1968
25b. REGISTRAR'S SIGNATURE	J. Charles Judge				

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12819 12829

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First: Lewis Middle: David Lost: Stonesifer (Stonesifer)

2a. DATE OF DEATH Month: 9 Doy: 1 Yeor: 68

2b. HOUR: 2 30 PM

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH: 8/30/68

6. AGE (In yeors last birthday): — YRS. IF UNDER 1 YEAR MONTHS: — DAYS: 3 IF UNDER 24 HRS. HOURS: MIN:

7a. BIRTHPLACE (Stote or foreign country): Carroll Co., Md.

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. COUNTY OF DEATH: 2 Carroll Md.

10. CITY OR TOWN OF DEATH: Westminster

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress): Carroll County General Hospital

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): None - Infant

12b. KIND OF BUSINESS OR INDUSTRY:

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Mothers Md.

13b. COUNTY: Carroll

13c. CITY OR TOWN: Westminster

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET AND NUMBER: 72 Wimert Ave.

14. FATHER'S NAME First: Michael Middle: T Lost: Stonesifer

15. MOTHER'S MAIDEN NAME First: Judith Middle: E. Lost: Morningstar

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: —

(If yes give wor or dotes of service): —

16b. SOCIAL SECURITY NO.: —

17. INFORMANT: Michael T. Stonesifer Address: 72 Wimert Ave. Westminster, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (o), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (o): Prematurity 2lb 2oz

DUE TO, OR AS A CONSEQUENCE OF

(b):

DUE TO, OR AS A CONSEQUENCE OF

(c):

777X

Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse lost.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)

776X

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer)

21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19

21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐

21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)

21f. LOCATION Street or R.F.D. No. City or Town County Stote

22a. **I certify** that (I) (this hospital) attended the deceased from 8-30, 19 68, to 9-1, 19 68, that (I) (~~we~~) last saw the deceased alive an 9-1 19 68, and that in (~~my~~) (our) opinian death accurred an the date and haur and from the causes stated abave, (I) (~~we~~) (did) (~~did not~~) view the bady after death.

22b. SIGNATURE: Carl M. Gund DEGREE ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. DATE SIGNED: 9/1/68

22d. PHYSICIAN'S NAME (Type)

22e. ADDRESS: Westminster, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 9/2/68

23c. NAME OF CEMETERY OR CREMATORY: St. Marys Cemetery

23d. LOCATION (City or Town) (County) (Stote): Silver Run, Carroll Co., Md.

24. FUNERAL DIRECTOR: Richard A. Little ADDRESS: Littlestown, Pa.

25a. REC'D BY REGISTRAR DATE: SEP 3 1968

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (M) 30M REV. 1/68

81-20749

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12820

CERTIFICATE OF DEATH

12830

1. DECEASED-NAME (Type or print) First	Middle	Lost	2a. DATE OF DEATH Month Day Year	2b. HOUR
Bessie	-	Taylor	9 Month 24 Day 68 Year	3:40 am M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
female	white	5/20/82	86 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Scotland	USA		Carroll Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
Rural--Sykesville	Springfield State Hospital	R.N. (retired)	Nursing

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	—	Baltimore	YES ☒ NO ☐	5703 The Alameda

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Thomas	-	Taylor	Elizabeth	-	Thompson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
no	217-12-7006	Springfield Hospital records, Sykesville, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Pneumonia	days
DUE TO, OR AS A CONSEQUENCE OF (b)	Congestive Heart Failure	hours
DUE TO, OR AS A CONSEQUENCE OF (c)	Arteriosclerotic Heart Disease	years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4129

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

4200 Chronic Brain Syndrome

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that ~~I~~ (this hospital) attended the deceased from 6/6/ , 1967 , to 9/24/ , 1968 , that ~~I~~ (we) last saw the deceased alive on 9/24/ 1968 , and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated above, ~~I~~ (we) (did) ~~did not~~ view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Gracito V. Patricio		☐	☐	☒	9/24/68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
GRACITO V. PATRICIO	Springfield State Hospital Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	9/27/68	Moreland Memorial Pk.	Parkville, Balto.Co., Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
H.W.Jenkins & Sons Co.	4905 York Rd. Balto.12, Md.	SEP 26 1968	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-(4)
30M REV. 1-68

Items 1, 5, 13, 14 & 15
Film 405 10/17/68 kk

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12821 — 12831

1. DECEASED-NAME (Type or print) First: Alice (Mrs)	Middle: E.	Last: Wahle	2a. DATE OF DEATH Month: 9 Day: 30 Year: 68	2b. HOUR: 3:14 M		
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: 4-4-98	6. AGE (In years last birthday): 70 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country): Virginia	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Carroll County, Md.			
10. CITY OR TOWN OF DEATH: Sykesville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Springfield State Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife	12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland-	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Rockville	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 5715 Arundel Rounder Avenue		
14. FATHER'S NAME First: Richard	Middle: Henry	Last: Edwards	15. MOTHER'S MAIDEN NAME First: Alice	Middle: Barnes	Last:	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: - (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 332-28-7186	17. INFORMANT: Records, Springfield State Hospital	Address:			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Pulmonary embolism.

DUE TO, OR AS A CONSEQUENCE OF

(b): Carcinoma of colon.

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 153.8 / 153.8

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Chronic brain syndrome associated with cerebral arteriosclerosis with neurotic reaction

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 7-26-68 19___, to 9-30-68 19___, that (I) (we) last saw the deceased alive on 9-30-68 19___, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE: ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒	22c. DATE SIGNED
Paul G. Ensor M.D.		9-30-68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Paul G. Ensor, M.D.	Springfield State Hospital

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	10-2-68	Arlington National Cem	Arlington Va.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
C W Chambers Co. 1400 Chapin St. NW	OCT 9 1968	J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

4 1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12822 12832

1. DECEASED-NAME (Type or Print) First / Middle / Last: ORVILLE ETHELBERT WEBER					2a. DATE KNOWN OF DEATH ESTIMATED ☐: Month 9 Day 4 Year 1968	2b. HOUR 6:30 P M
3. SEX: MALE	4. RACE: White	5. DATE OF BIRTH: Nov 25, 1902	6. AGE (In years last birthday): 65 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.		2c. DATE PRONOUNCED DEAD: Month 9 Day 4 Year 1968	2d. HOUR 6:30 P M
7a. BIRTHPLACE (State or foreign country): PA.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐		9. COUNTY OF DEATH: CARROLL Md.		
10. CITY OR TOWN OF DEATH: SYKESVILLE	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SPRINGFIELD STATE HOSP.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): TEACHER	12b. KIND OF BUSINESS OR INDUSTRY: Schools			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: BALTIMORE	13c. CITY OR TOWN: RANDALLSTOWN	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 3415 OFFUTT ROAD,		
14. FATHER'S NAME First / Middle / Last: SAMUEL E. WEBER		15. MOTHER'S MAIDEN NAME First / Middle / Last: MARY L. KNORR				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No	(If yes give war or dates of service): —	16b. SOCIAL SECURITY NO.: 163-14-8992	17. INFORMANT: MRS ANNE S. WEBER	ADDRESS: ABOVE.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Minutes
DUE TO, OR AS A CONSEQUENCE OF (b): Ingested Food
DUE TO, OR AS A CONSEQUENCE OF (c): old Myocardial Infarction Healed years
Conditians, if any, which gave rise to immediate cause (a), stating the underlying cause last. 911 X 921.9

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Presenile Psychosis (Alzheimers)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Yeor HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Port 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factary, affice building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held an Autapsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined monner ☐

ACTUAL SIGNATURE: W. Glenn Speicher — CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): W. GLENN SPEICHER, 135 E. Main St. Westminster Md. (Address: Street, Town, or County)

22b. DATE SIGNED: 9-5-68

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	9-7-68	Lake View Memorial	Sykesville Carroll Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Luther H. Haight	Sykesville, Md.	SEP 10 1968	J. Charles Judge

VR A15ME (5)
10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12822 12833

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: Emma	Middle: Gladys	Last: Wolfensberger	2a. DATE OF DEATH: Month 9 Day 3 Year 68	2b. HOUR: 10:00 p.m.
3. SEX: female	4. RACE: white	5. DATE OF BIRTH: 9/18/01	6. AGE (In years last birthday): 66 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Carroll Md.		
10. CITY OR TOWN OF DEATH: Rural--Sykesville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Springfield State Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): factory worker	12b. KIND OF BUSINESS OR INDUSTRY: --		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Washington	13c. CITY OR TOWN: Hagerstown	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 140 N. Locust Street	
14. FATHER'S NAME First: Benjamin	Middle: Shaddrec	Last:	15. MOTHER'S MAIDEN NAME First: Emma	Middle:	Last: Anthony
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: no (If yes give war or dates of service): --	16b. SOCIAL SECURITY NO.: 214-09-4312A	17. INFORMANT Address: Springfield Hospital records, Sykesville, Md.			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia, bilateral
DUE TO, OR AS A CONSEQUENCE OF
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
486 X
490 X
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: days

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Chronic Brain Syndrome 2° to Arteriosclerotic cardiovascular disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that [X] (this hospital) attended the deceased from 4/4/ , 1966 , to 9/3/ , 1968 , that [X] (we) last saw the deceased alive on 9/3/ 1968 , and that in [X] (our) opinion death occurred on the date and hour and from the causes stated above, [X] (we) (did) (did not) view the body after death.

22b. SIGNATURE: Glorita G. Sagisi DEGREE: ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]

22c. DATE SIGNED: 9/3/68

22d. PHYSICIAN'S NAME (Type): Glocrita G. Sagisi, M. D.

22e. ADDRESS: Springfield State Hospital Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
Burial	9/6/68	Salem Reformed Cemetery	near Cearfoss	Wash Co	Md

24. FUNERAL DIRECTOR: Hoffman Funeral Home Inc ADDRESS: Hagerstown Md.

25a. REC'D BY REGISTRAR DATE: SEP 6 1968

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4) 30M REV. 7-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12824 — 12834

1. DECEASED-NAME (Type or print)	First: SARAH	Middle: JANE	Last: YOUNG	2a. DATE OF DEATH Month: SEPT. Day: 7 Year: 68	2b. HOUR: 3:P.M	
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH: APRIL 10, 1885	6. AGE (In years last birthday): 83 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country): PENNA.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐	9. COUNTY OF DEATH: CARROLL Co. Md.			
10. CITY OR TOWN OF DEATH: MARRIOTTSVILLE	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress): 38 MARRIOTTSVILLE ROAD	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): HOUSE-WIFE	12b. KIND OF BUSINESS OR INDUSTRY: —			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: CARROLL Co	13c. CITY OR TOWN: WESTMINSTER	13d. INSIDE CITY LIMITS? YES ☐ NO ☑	13e. STREET AND NUMBER: 245 FOWLER ROAD		
14. FATHER'S NAME First: JOHN	Middle	Last: JONES	15. MOTHER'S MAIDEN NAME First: BARBARA	Middle	Last: GETTLE	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or upknown): NO (If yes give war or dates of service): —	16b. SOCIAL SECURITY NO.: 216-28-2586	17. INFORMANT: RUSSELL T. YOUNG	Address: 212 WASHINGTON RD, WESTMINSTER MD.			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: acute
4109
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
DUE TO, OR AS A CONSEQUENCE OF
(b): Arteriosclerotic Cardiovascular Disease — unknown
DUE TO, OR AS A CONSEQUENCE OF
(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 Gastroenteritis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / Stote	

22a. **I certify** that (I) (this hospital) attended the deceased from Jan. 21, 19 68, to Sept. 7, 19 68, that (I) (we) last saw the deceased alive an Sept. 7 19 68; and thot in (my) (our) opinion death occurred on the date ond hour ond from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Philip W. Mercer M.D. DEGREE	ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 9/9/68	
22d. PHYSICIAN'S NAME (Type): Philip W. Mercer M.D.	22e. ADDRESS: Westminster, Md.		

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: 9/10/68	23c. NAME OF CEMETERY OR CREMATORY: TAYLORSVILLE METH. CEM.	23d. LOCATION (City or Town): TAYLORSVILLE	(County): CARROLL MD (State)
24. FUNERAL DIRECTOR: J. S. Myers Jr.	ADDRESS: Westminster, Md.	25a. REC'D BY REGISTRAR DATE: SEP 11 1968	25b. REGISTRAR'S SIGNATURE: Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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